



Using CAHPS Item Sets that Address Cultural Competence and Health Literacy

Moderator: Carla Zema, Consultant, CAHPS User Network; Assistant Professor of Economics and Health Policy, Saint Vincent College

Speakers:

Cindy Brach, Senior Health Policy Researcher, Agency for Healthcare Research and Quality (AHRQ)

Robert Weech-Maldonado, Professor & L.R. Jordan Endowed Chair, Department of Health Services Administration, University of Alabama at Birmingham

Beverly Weidmer, Survey Director, Survey Research Group, RAND

Carla Zema

Good afternoon and welcome to our webcast on Using CAHPS Item Sets that Address Cultural Competence and Health Literacy. My name is Carla Zema and I will be the moderator for today's webcast. Today's webcast is in of a series of webcasts on CAHPS which stands for Consumer Assessment of Healthcare Providers and System produced by the CAHPS User Network.

I see from the registration that many of you have little or no familiarity with CAHPS surveys so I want to take a few minutes to give you some background on the CAHPS program. Primarily funded by the Agency for Healthcare Research and Quality or AHRQ, the CAHPS program develops standardized surveys and related products according to established principles. CAHPS surveys assess patients experience with health care. A consortium of organizations contributes to the CAHPS program. The CAHPS User Network is administrated by Westat under contract of AHRQ. The consortium also includes the RAND and Yale grantees research team as well as many other government and private stakeholders all with the common interest in measuring and improving the patient care experience. CAHPS surveys are a family of surveys for assessing the patient care experience for both ambulatory and facility based care.

The CAHPS Clinician & Group Survey, or C&G Survey for short, is highlighted in this list since it is the focus of our webcast. The C&G Survey is designed to assess patient experience of care within medical groups and practices as well as individual clinicians or practitioners. First and foremost is the emphasis on patients.

CAHPS surveys measure aspects of care that are important to patients as well as those for which patients are the best or only source of information. For example, CAHPS surveys do not ask about technical quality because you wouldn't expect patients to be the best source of that information. Given the emphasis on patients, all CAHPS products undergo extensive testing with patients. CAHPS surveys are not satisfaction surveys rather, they ask patients to report on their actual experiences of care. Standardization is critical not only for CAHPS surveys but also for data collection protocols, analysis, reporting, and benchmarking. CAHPS surveys often have multiple versions for diverse populations. For example, the C&G surveys has versions for both primary and specialty care and a new version that we are developing to assess the Patient-Centered Medical

Home [Survey]. All CAHPS surveys are free and in the public domain to ensure broad views and easy access. All CAHPS surveys undergo a rigorous development process to ensure their validity and reliability. To give you an example that is especially relevant to today's discussion is a translation process. The CAHPS items are not merely translated. They go through two forward translations, then an expert committee reconciles differences in the translations to ensure that the translated items have the same contextual meaning.

The item sets that you are going to hear about today have gone through this rigorous development process. So all of the CAHPS Clinician & Group Survey questionnaires have a core questionnaire that standardizes items for all versions of the survey. You can add supplemental items to get a customized CAHPS survey and the two item sets that we are talking about today are supplemental item sets that you can add to the core CAHPS Clinician & Group Survey.

We are pleased to welcome three outstanding speakers for today's program. Joining us from AHRQ is Cindy Brach who is the Program Lead for Cultural Competence and Health Literacy at the agency. We are also joined by Robert Weech-Maldonado from the University of Alabama at Birmingham. Rob has served as a member of the Cultural Comparability Team with the CAHPS Consortium for many years. From the CAHPS RAND grantee team we have Beverly Weidmer. Beverly has served several roles as part of the CAHPS Consortium including leading all of our translation work for CAHPS surveys and being a member of the Cultural Comparability Team. Again, I am Carla Zema and I will be serving as moderator for today's webcast. I am a consultant with the CAHPS Consortium and a faculty member at St. Vincent College.

We have a lot of great material to share with you during today's webcast. First, Cindy will be discussing the importance of health literacy and cultural competence as well as presenting a framework for these areas. Rob will give you a review of the new CAHPS Cultural Competence Item Set and discuss not only how to use the item set but also what you can do with the results that you get. Beverly will review the CAHPS Addressing Health Literacy Item Set and talk about how to use the item set. She will also present interventions that providers can use to improve how they communicate with patients with low health literacy.

As always, we plan to allow time for lots of questions and we will do our best to answer as many as possible. To ask a question, simply select "ask a question" from the navigation bar at the bottom of your screen as shown circled here. All you need to do is type in your question in the text box and select submit. Please feel free to send in your questions during the presentations and we will address them during the Q&A session. We know from previous webcasts that participants really value the Q&A session and we really want to hear from you so please send in your questions.

At any time during the webcast, you can access slides, documents, resource information, and the phone numbers by selecting the "event materials" tab at the bottom of your screen. Finally, if you need help at any time during this webcast, select "help" on the upper-right portion of your screen. If you are dialed in to the telephone line to hear audio you can also dial star [*] 0. A common problem is not being able to hear the webcast through your computer speakers. You can join us by phone any time by dialing 1 (877) 407-4035 and entering the pass code 358844 pound [#].

Another common problem is having your computer freeze during the presentation. Hit your F5 button on the keyboard to refresh your screen. Remember though that you may just be experiencing a lag in the advancement of the slides due to your internet connection speeds. You can also try logging out and logging back in to the webcast. Finally, you can also call for technical help directly at 1 (866) 490-5412.

Now on with the program. Cindy, why don't you tell us a little bit about how the agency approaches health literacy and cultural competence?

Cindy Brach

Thanks a lot, Carla. I'm just going to try and give you a little context of how we approached the development of these item sets in terms of why we even thought there was something that we needed to be asking patients about. One of the things that we know is that there is a mismatch between individual health literacy skills and the demands that are made of them and when I talk about the demand -- health literacy demands, I'm just going to flip so you can see a list of them here. We ask patients to do a lot of different things. Even before they get to the doctor's office they've got to choose a doctor and find the building. We also have very high level demands. Increasingly, we're asking patients to self-manage their conditions, they may have complex medicine regimens, they've got to deal with insurance so that there are a whole bunch of things that we're asking consumers to wrestle with and their individual ability to do that really varies.

And I apologize; I'm getting the right slide up now. No, I'm not and I assured them all that I was very adept at this. All right just bear with me one second I have to go back to this problem. So that -- something is happening here. Okay. Apologies.

So health literacy is one piece of it. We also know that there are over 22 million Americans who don't speak English very well and we know that there are a lot of racial and ethnic disparities in health care and health outcomes. Another issue that we felt we needed to address with these item sets is the fact that racial and ethnic minorities are more likely to experience racism and distrust their health care providers. And these are all things as Carla mentioned, that patient reports of can be very helpful.

So I am going to talk a little bit about health literacy now and then move onto cultural competence. Health literacy-- this definition is the one that is used in the Affordable Care Act. It's a slight variant on one that's been around for over a decade used Healthy People, used by the IOM, the Institute of Medicine, and you can see it talks about individuals abilities to be able to obtain process and understand health information. But we know that health literacy is more than just what an individual skills and abilities are. It's actually a product of those skills and abilities and the demands or the complexity of the health information that we give them. So that health literacy is really a product of those two things even though when we talk about health literacy measurements often people are talking about measuring an individual's abilities.

So for those of you who are visual learners, I put up a model up here that kind of shows you how this comes together and on the left-hand side, you see individual capacity and that's what the person brings: their reading abilities, their prior knowledge, etc. And then in the yellow highlighted square boxes, that are in the center section, show where the complexity or the difficulty of the messages come in. And you'll notice that these are both written messages and spoken messages that health literacy's not just about reading and writing, but it's also being able to understand health information that is communicated orally and our model here is that the combination of those individual abilities and the difficulty is what is going to lead to changes in behavior and knowledge which in turn are going to result in improved outcomes. Cultural competence you see here is defined by a[n] ability to work effectively in cross cultural situations but the definition unfortunately, doesn't really tell you what to do in order to be effective in those situations.

So on this next slide, you'll see a list of -- sorry we have a delay here -- we see a list of cultural competence interventions and those are examples of the kinds of things that you might do in order to be culturally competent in a cross cultural situation. The first three-- interpreter services, bilingual

clinicians and staff, translated materials, those all pertain to when individuals have language barriers or limited English proficiencies but there are other strategies including having a staff that demographically looks like the population you're serving. Training clinicians and staff, using community health workers, cultural competent health promotions. And again, the model of what difference this makes is very similar to the health literacy model that you apply an intervention to a diverse population.

You're going to see changes in either clinician or patient behavior or both. This is going to lead to more appropriate services and ultimately better health outcomes. Though there are other things that are driving organizations and individuals to want to pursue cultural competence or health literacy and this is a list of a number of them beginning with antidiscrimination legislation at the federal level going through national statements such as the National Standards on Culturally and Linguistically Appropriate Services or the recently released National Action Plan to improve health literacy so that there is an effort from the Department of Health and Human Services and joining with partners, public and private across the nation, to really address these issues. And then you also see that there are accrediting agencies who are involved in trying to put forth standards and strategies. And finally, we even have sort of malpractice hanging over one's head in that there have been cases in which malpractice awards have been awarded because there wasn't a real communication in and informed consent situation or other situations.

So cultural competence and health literacy really come together in a couple of different ways. One is that there's an overlap in these populations. You'll see here in the far left column that only 12 percent of U.S. adults in general are proficient in their health literacy and that means that they really have everything that they need to operate effectively in today's health care system. But there's over a third of Americans who have what we call limited health literacy denoted by those bottom two categories, the basic or below basic and what you see as you look across this graph is that minority Americans are disproportionately affected by limited health literacy so we see for example, in the column labeled black that over a 1/2 of black adult Americans have limited health literacy and when you get to the Hispanic column you see that that jumps fully 2/3. So that there's an overlap in that literal sense in terms of some of the people who are experiencing both of these situations. But there are other common themes around the fact that both health literacy and cultural competence are aimed at serving the needs of diverse patients. They're also about adapting our health care system to meet the needs of our patient populations and they have a common theme of trying to improve communication with patients and engaging with patients and their families. So with that, I'm going to turn it back to Carla.

Carla Zema

Great, thank you so much, Cindy. Rob is now going to tell us about the new Cultural Competence Item Set.

Robert Weech-Maldonado

Yes, hello everyone and thanks so much for joining us today. I would like before -- the next slide please -- to acknowledge my collaborators in this project: Adam Carle, Beverly Weidmer, Margarita Hurtado, Quyen Ngo-Metzger, and Ron Hays.

Next slide. As you will see in this slide and there are different types of assessments of cultural competence and each one of them is important because they provide a different perspective on cultural competence. We have organizational types of assessments that provide information on structures, policies and system practices that can serve as facilitators of cultural competence. One example of an organizational assessment is the CCATH which was a project funded by the DHSS Office of Minority Health and the Commonwealth Fund and this instrument actually measures adherence to class standards. There are also provider of assessments which would assess the cultural competence of practitioners including physicians, nurses, and other providers and finally, we have patients -- Patient Assessments of Cultural Competence, which is the focus of this presentation, which as the name implies, provides the patient's perspective. This project was actually initially called the Patient Assessments of Cultural Competency and we use the acronym of PACC and now it has been transitioned to the CAHPS Cultural Competence Item Set.

Next slide. In this slide, you will see the actual development process of the CAHPS Cultural Competence Item Set and as Carla introduced it at the beginning, it is typical of other CAHPS instruments. And we start with the development of the conceptual model and as well as the development and translation of the items, then we subject the item set into the rigorous cognitive interviewing and then after the revisions based on the cognitive testing, we field test[ed] the item set with members of two Medicaid Managed Care Plans.

In the next slide, we're going to present the actual conceptual framework we use in developing this item set. And this came from work from Ngo-Metzger and colleagues where they were trying to establish a framework for obtaining the patient's perspective on culturally competent care and as you can see in this framework, health care is experienced by the patient in the context of interactions with providers within the health care system and there are three factors that affect the quality of care for a diverse population -- patient factors, provider factors, and health care system factors. And we focus on, in essence, five domains that overlap within those three factors and those are patient provider communication, respect for patient preferences or shared decision-making, experiences leading to trust or distrust, experiences with discrimination, and language services.

In the next slide, you will see the major analyses that we conducted. First, we conducted the psychometric analysis to assess the internal consistency and construct validity of the measures. In addition we conducted regression analysis where we were interested in examining the relationship between the CAHPS Cultural Competence domains and the CAHPS overall doctor rating scores, while controlling at the same time for CAHPS measures that are used in case mix adjusting such as gender, age, education, and perceived health status.

In the next slide, you'll see the major results of the analysis. We basically, in the confirmatory factor analysis, were able to show support for eight factors or domains and also we found a significant positive relationship between the scores for the Cultural Competence domains and the overall doctor rating. So for example, we found that higher patient scores on trust were associated with higher doctor ratings.

In the next slides we are going to now be talking more specifically about the Cultural Competence Item Set. This slide actually provides an overview of all the different areas that we cover in this item set. First, we have three reporting composites, one of them relates to doctors who are polite and considerate, the other one, doctors give advice on staying healthy, and the third one, doctors are caring and inspire trust. Then we have five other areas, one of them looking at doctor, communication-alternative medicine, equitable treatment, shared decision-making, language access, and two overall ratings on trust and services.

In the next slide, we're going to start going into more detail into each of these measures. First, we have, like I mentioned, the reporting composites and the first one is doctors are polite and considerate and as you can see, this composite actually looks at behaviors that would be negative in terms of doctor communication. Now these items would be reverse scored so that that way the composite score would be in a positive direction. The next reporting composite relates to physician patient communication and health promotion issues such as healthy diet, exercise, and stress.

In the next slide, you will see the third reporting composite and this is the one that relates to patient perceptions of trust, whether the patient feels that they can tell the doctor anything, trust the doctor with the medical care, and other perceptions of the patient that relate to trust.

In the next slide, we present three topic areas that are covered by the Cultural Competence Item Set. First, we look at doctor communication relating to alternative medicine and this is focusing on whether the doctor asks the patient about their use of an acupuncturist or herbalist as well as the use of natural herbs. We also have a topic relating to equitable treatment and this relates to perceptions of unfair treatment based on three areas: race/ethnicity, insurance, and language. The third one is related to shared decision-making, where we're basically inquiring about the patients whether the physician respects patient preferences and whether their participation is actually promoted in the decision-making. Now I should mention that currently, there is an expanded item set that is being fielded and that the results of this will be available in the summer through the Patient-Centered Medical Home Survey. The next topic area relates to language access and this is an item, or a part of the item set, that we have dedicated a substantial amount of time and as you can see there are 17 items and we assess both the need for interpreter services but, also the access to interpreter services by inquiring about patients being aware of their right to interpreter services, about the timeliness of the services, courtesy and respect by the interpreter and also whether the patient had to use family and friends because there was no interpreter available at the site.

Finally, in terms of the topics, we have, like I mentioned in the overview slide, we have two ratings, one related to trust and then the other one related to the interpreter that was provided by the doctor's office most often. All right, so now that we have an overview of all the different topics in the Cultural Competence Item Set, I guess one of the questions that you may have is "Well, there are so many different areas, how do I identify priorities?" One of the things that, you know, we have to keep in mind is that cultural competence is a multidimensional concept, as you can remember from the framework that I presented, so all of these dimensions are important. However, based on our analysis we can tell you that there were three areas that were particularly correlated or associated with the overall doctor rating and these three areas were relating to: doctors are polite and considerate; doctors are caring and inspire trust; and equitable treatment. By the way, the first two are reporting composites and equitable treatment is one of the other topics that I mentioned before.

The other question, next slide, you may ask is "How can I use the results from this survey in quality improvement?" And you know, basically we would propose a quality improvement process or framework where you would start by assessing the baseline performance, examine your scores by topic area as well as for your individual items. This will help you identify areas of strengths and weaknesses. It is important of course, given the focus of this item set, to look at racial, ethnic, and language differences. Oftentimes the numbers may be inadequate so it is important to oversample these populations so that you get enough people in the survey so to be able to look at group differences or subgroup differences. If you have the resources available, it would be important or helpful to do focus groups because generally these will provide qualitative data that can provide further insights into the data you collected in the survey. Now once you have the data, then you can start thinking about identifying and implementing an action plan to address the gaps from the survey results and ultimately you want to evaluate the effectiveness of that action plan. Potentially by

administering again the CAHPS Cultural Competence Item Set in looking at the pre- and post scores. Ultimately, of course, it is important to strive for continuous improvement and just revisit this process as often as possible.

Next slide. Another area that -- or application for the results of this survey -- is how can we use them to provide or to use the results for provider feedback and I can see there are two areas that -- or two different applications in which this can be used. First, if you are a health system, you may be able to use the composite reports that we mentioned to compare performance across member provider groups and like I mentioned before there are three reporting composites that can be used for this purpose. Another application would be, and actually providing more detailed feedback reports to individual providers, and this would help providers in identifying behaviors that may hinder effective communication. And some of those may be specifically negative communication behaviors. For example, interrupting patients, talking too fast, behaviors relating to shared decision-making, related to communication and alternative medicine and courtesy and respect by the interpreter. So these are just examples of behaviors that you would be able to identify by providing feedback reports to your individual providers.

Now I would like to emphasize as you can see in the next slide that using the CAHPS Cultural Competence Item Set should not be viewed as a stand-alone effort. That it is something applicable to doctor/patient communication. It is important that cultural competence interventions follow a systems approach and the National Quality Forum actually provides a useful framework on a systems approach and as you can see in this slide there are seven domains and there are also 45 preferred practices in this framework. As you can see it starts with the organizational leadership. It also includes integrating cultural competence into the management systems and operations, patient-provider communication, care delivery and supporting mechanisms, workforce diversity and training, community engagement, data collection, public accountability, and quality improvement. Again, the idea would be that cultural competence should be integrated across all of the aspects of the organization. And this will of course facilitate patient-provider communication as well.

In the next slide, I'm going to be giving you examples of all of these different domains and I just chose for each of them a preferred practice, just to give you a sense about what the domain is about. And as you can see leadership, preferred practices, having a commitment by being reflected in the vision, goals and mission of the organization. Implementing reward and recognition programs is part of the integration into management systems and operations. Adapting the physical environment for diverse populations is the preferred practice for care delivery and supporting mechanisms.

In the next slide, you see the other two -- or two other domains. We are implementing training that builds a workforce that is able to address the needs of a diverse population as part of the workforce diversity and training. Providing language access resources is part of the patient-provider communication.

The next slide we have the final two domains in examples of preferred practices and one of them, one of the preferred practices, utilizing formal and informal mechanisms to facilitate community involvement, that's part of the community engagement and the last one we have assessing and improving patient and family-centered communication as part of that last domain on data collection, public accountability, and quality improvement. And by using of course, the CAHPS Cultural Competence would be part of that preferred practice which is assessing patient-centered communication.

So in the next slide, we have the conclusions of the project for this presentation and as you can see we can say that the CAHPS Cultural Competence Item Set addresses culturally competent care from

the patient perspective. The analysis has shown that the survey has adequate measurement properties at least from a psychometric perspective. It addresses aspects of care that are important to patient's ratings of care as we saw from some of the regression analysis. We know also that it relates to some of the Joint Commission 2009 Requirements on the Provision of Culturally and Linguistically Appropriate Health care.

The next slide -- I would like to mention some of the resources that are available and just remember that you can access this list of resources through the event material sections of the webcast. But this is just a partial list of the resources that are available on cultural competence and different tools and instruments that can be used in this area. Finally, I would like to acknowledge the funders of the study AHRQ and the Commonwealth Fund as well as the staff, the project -- the staff at each of those organizations. I would like to also acknowledge the CAHPS Consortium as well as the valuable feedback that we received from the different CAHPS teams. I would like to acknowledge the University of California, San Francisco, and the University of Wisconsin-Madison and finally I would like to acknowledge the Medicaid Managed Care Plans. Thank you very much.

Carla Zema

Thanks so much, Rob. We are so excited to have this item set being released. We know there's a lot of interest in it and we've heard from a lot of users how important this topic is so we look forward to working with our users to implement it. A lot of you have asked how you access the items themselves. Remember that on the events tab, you can click on links that would take you to each of the item sets that we are presenting; [we] have what we call an about document, which gives you a description of the item sets as well as in the appendix, has a full listing of the items. The items themselves are also part of the CAHPS Clinician & Group Survey and Reporting Kit, which there is also a link. The Health Literacy Item Set is already a part of that kit and we are working to post the Cultural Competence Item Set within the next few days. That is where you would find all of the response options and placement instructions on how to use them with the full Clinician & Group Survey. So now I want to turn it over to Beverly Weidmer who is going to tell us all about the CAHPS Item Set for Addressing Health Literacy. Beverly.

Beverly Weidmer

Thank you, Carla. And thank you all for joining this web presentation today. As Carla mentioned, we're very enthused by the interest and the number of people that have logged on to listen to our presentations today.

So as Carla mentioned, I'm going to be talking to you about the CAHPS Item Set for Addressing Health Literacy. The focus of my presentation will be primarily on the Health Literacy Item Set that we've developed as the supplemental item for the Clinician & Group Survey. But I do know that some of you are interested in the item sets that is also being developed for both the H-CAHPS, the Hospital CAHPS Survey, as well as the CAHPS Health Plan Survey. And I will mention those towards the end of my presentation.

And as Cindy Brach mentioned at the beginning of her presentation, in recent years, we've seen an increased awareness of the mismatch between patient skills and the health literacy demands that are placed on them and also a growing recognition that health care professionals have a responsibility to improve patients understanding. In addition, there is a growing body of research that has shown that low health literacy is both common and that individuals with low health literacy are more prone to

medication errors, have poor adherence to recommended medication or treatment, have poorer health status, have worse health outcomes and are more likely to be hospitalized. In addition, those with low health literacy have poorer knowledge of their disease, poorer disease health management skills, and lower use of preventive health services.

So all in all, we're seeing an increased awareness of the problems associated with health literacy and an increased interest on the part of health providers and systems to do something about it. This interest has culminated in a national focus on health literacy primarily through the National Action Plan to Improve Health Literacy which, is an action plan that seeks to engage organizations, professionals, policymakers, you know, just individuals across the board, in a multi-sector effort to improve the health literacy. At the same time, we've been hearing from users and from stakeholders that they would be interested in having a measure that focused on health literacy as part of the CAHPS surveys. The CAHPS surveys are a logical vehicle for including a set of items focused on health literacy both because they're widely used across different health care settings and -- or also widely accepted by health providers and have been shown to be reliable and they're often used for quality improvement purposes already. So that gives you a little bit of background about why we were motivated to develop a set of items focused on health literacy as a part of CAHPS. The project, focus on health literacy, has been ongoing for the last five years with funding from AHRQ like all of CAHPS.

Next slide please. What we have been hearing in recent years in terms of the need for an item set focused on health literacy is that health providers and users of CAHPS surveys need tools or survey measures that can help them to identify areas for quality improvement, both at the clinician and at the group level, tools that can help them evaluate quality improvement activities that are designed specifically on improving communication with patients, that they can use to report quality data back to physicians and other health providers, and in some cases, even to provide information back to consumers. So in response to this expressed need on the part of CAHPS users as I said, we set out to develop an item set that specifically focused on health literacy. And what we're trying to do with this measure is to design a set of supplemental items that will measure patients' perspectives on how often health care professionals are providing easy to understand information and assistance with health literacy tasks and what things they are doing in their day-to-day practice to enhance patients' health literacy skills. As I mentioned before, this is an item set that's designed as a supplemental item set for the CAHPS Clinician & Group Survey, so it's not a stand-alone survey measure, it really is designed as many other CAHPS supplemental items [as] something that can be used in conjunction with the core survey. And as I mentioned before, this is an item set that was developed by the CAHPS grantees under the leadership of RAND.

Next slide please. I'd like to talk to you a little bit about the development and testing of the supplemental item set that's focused on health literacy. As Carla described in some detail, you know, CAHPS has a set of guiding principles that it uses for developing its survey measures and items. And for evaluating and testing those items before making them publicly available. In developing our Health Literacy Item Set, we also use the same CAHPS development process and the same guiding principles for identifying, adapting, and developing and testing the measures. The first thing we did was conducted a fairly extensive environmental scan in the hopes of identifying other survey items or measures that were already in the public domain and that has been validated and tested that focused on issues related to health literacy or at the very least on issues related to how patients are communicating with their providers and how their providers are communicating with them in turn. Not surprisingly, we found very little that was in the public domain and so where we were able to find survey items we adapted them. In some cases, we borrowed them from OCKT [the Office of Communications and Knowledge Transfer] and in other cases where there wasn't a particular survey

measure for a particular health literacy topic we were interested in including, we had to develop the survey items from scratch.

We also conducted a stakeholder meeting where we invited key stakeholders to a one-day, in-person meeting. The stakeholders included researchers in the field of health literacy, clinicians, health plans, health literacy advocates, consumer advocates of course, as well as various representatives from government agencies such as CMS and the CDC, as well as representatives from other organizations like NCQA and the Joint Commission. And the purpose of the stakeholder meeting was you know, first and foremost, to present the item set to obtain feedback on the content of the item set, the topics and domains [that] should be included, and to obtain feedback on how we should be prioritizing the topics or the domains that we should include in the item set. And lastly we also sought input on how to disseminate the item set to insure the widest possible adoption.

Following the stakeholder meeting, we conducted a series of cognitive interviews in both English and Spanish. Prior to conducting the Spanish we of course, translated the survey items into Spanish using the CAHPS recommended translation approach involving two forward translations, review by a bilingual committee, and then decentering of the English as needed to make the Spanish version easier to understand. The cognitive interviews that we conducted are designed -- or were designed to assess the patient's understanding of the draft survey items. We wanted to make sure that they understood key concepts as intended and in addition, we wanted to ensure that the Spanish language version of the item set was appropriate, that is, we were trying to identify problems with the translation or possible confusion with some of the concepts that were presented in Spanish.

We used the cognitive interviews to identify terms, items, and response options that were problematic and then we irritably revised the item set and then tested it again until we produced a version that we felt comfortable the majority of respondents would be able to understand.

Following this series of cognitive testing that we did, we then moved to field testing the item set via mail with phone follow-ups. And this was a field test that was conducted with two different field test partners and, you know, as I said involved respondents who completed the survey in both English and Spanish, we fielded a sample of about 1200 patients and again, it was completed via mail with phone follow-up which allowed us to compare responses to both the mail survey and a telephone survey.

Following the field test, we conducted data analyses of the results specifically focused on evaluating the reliability and construct validity of the items included in the analyses and we looked at this by race and ethnicity. We also looked at whether the items could be used to discriminate among clinicians and plans on their CAHPS performance. We examined item missing data, we looked at item distribution, we looked at internal consistency and reliability of the composites, reliability of global rating items and the composites at the clinician level and also, of course, the correlation of composites or the items with the global ratings.

As Rob said about the Cultural Competence Item Set, we feel confident that we have a survey measure that can be used to adequately evaluate how well health providers are meeting their patients' health literacy needs in the clinician group setting.

Next slide please. In terms of the content of the item set that is a supplemental item set for the Clinician & Group Survey, it is made up of 29 items that users can choose from on six main topic areas.

The first topic is communication with doctors and nurses, communication about health problems and concerns, communication about medicines, communication about tests, communication about forms and then finally, disease self-management. Based on the results of the field test, we are actually only able to produce one reporting composite and that's the composite on communication about medicines and that includes the following measures. It includes:

- Does this doctor give you easy to understand instructions about how to take your medicines?
- Did this doctor explain the possible side effects of your medicines?
- Does this doctor explain the possible side effects of your medicines in a way that was easy to understand? So really, focusing on communication there.
- Did the doctor provide written information or write down information about how to take medicines?
- Was the information given easy to understand?
- And then finally, were they provided with ways to help them remember to take their medicines?

So that is the one reporting composite that is included as part of the item set. In terms of users and how they can use the item set, we recognize that 29 items is probably more items than any one user can field at one time and so what we try to do in publishing the item set is to provide the maximum flexibility by grouping items by topic or by domain and allowing users to pick and choose items depending on their interest or quality improvement focus. So these domains or topics allow users to really drill down and to obtain more actual information on a particular topic at the clinician level. So for example, if you're interested in communication about -- communication with providers or communication with a doctor, you could focus in on the questions that are related specifically to that.

So for example, things like how often does this doctor use medical words you did not understand? How often does the doctor talk too fast when talking with you? Did he use or she use pictures, drawings or models to explain things to you, etc? We have a whole series of items that are focused on communication with the doctor. If your interest is related to disease self-management we have a series of questions that are focused on what a doctor said and did to enhance patient's ability to manage their own health conditions.

As I mentioned, we have the communication composite that is focused on communication about medicines. We have a set of questions that get at communication about test results, a set of questions that get at communication about forms, so for example, did they give them a form to sign at the doctor's office and prior to signing it, whether someone explained the purpose of the form or whether they were offered help in filling it out, whether the form was available in Spanish, etc.

In addition to these topics that I've just described, users can also use the short version of the item set. And this short version of the item set is comprised of five items that based on the results of the field test we found were closely associated with the global rating of the doctor and provide feedback on various health literacy practices. So for example, we have item nine which is did the doctor give you all the information you wanted about your health? Item 10, did the doctor encourage you to talk about all your health problems or concerns? Item 19, did the doctor ask you to describe how you're going to follow instructions? And finally, item 25, which is focused on blood test, X-rays, or other tests and whether they were provided results in a way that was easy to understand. So that's again, a short version of the item set that users who want to get a sense of how they're doing in terms of the health literacy practices could choose to field those five items alone.

Next slide please. And to assist practices in determining how to address an area needing improvement, AHRQ has mapped each item in an item set for addressing health literacy to a health literacy practice that was recommended by the American Medical Association and this could be found in the AMA monograph titled *Health Literacy and Patient Safety: Help Patients Understand*. And

again it is one of the resources available to the CAHPS website if you log on to the event log you will find a link to the CAHPS website and that will also have a link to the AMA -- their quality improvement guide. You can also use the crosswalk that's posted with the item set to identify items that will help you evaluate the implementation of a particular AMA recommendation and for specific techniques and strategies to facilitate the AMA recommendation. Again, you can refer to the monograph that's provided by the AMA.

But I would just like to quickly walk through the quality improvement crosswalk that we've provided. So for example, if you look at the health literacy question number one, How often were the explanations the doctor gave you hard to understand because of an accent or the way the doctor spoke English? This has been crosswalked to one of the AMA recommendations that recommends that providers slow down, that they use plain language and short statements, that they ask for teach-back to ensure patient understanding of what the doctor has said. For example, if you look at question two, How often did this doctor use medical words you did not understand? That relates specifically to using plain, nonmedical language. So as you can see, we mapped all 29 of the items to an AMA recommendation that can be used for quality improvement.

And I am going to actually jump forward to slide 16 please. In terms of using the item set to improve health literacy practices again, users can use the item set as part of the Clinician & Group Survey to identify topic areas for quality improvements.

For example, communication about medicines, to recognize particular behaviors at the clinician level that inhibit effective communication, so things like talking too fast or using medical jargon or ignoring information that patients are trying to share with you to assist in designing a shame-free environment where patients feel comfortable in discussing health care concerns. So, you know, in theory that should be the goal -- we should all be striving to design and promote a shame-free environment where patients feel comfortable in communicating about all their health problems and concerns with their primary care doctor or nurses.

In using the Health Literacy Item Set, you can also measure effect of behaviors that promote effective communication. So for example, you can evaluate whether confirming understanding through teach-back is something that's having an effect. Whether using visual aids is a strategy that's improving communication. Whether patients perceive that they were being offered assistance in completing forms prior to being asked to sign them and then, of course, you can use the item set to evaluate the impact of quality of improvement activities over time. So you can measure it, implement your quality improvement activity, then use the item set again to measure the effect of your quality improvement activity over time. In terms of reporting the results, the results can be reported at the individual clinician level, they can be aggregated at the group level, so for example, at the medical practice or clinic level, and users can also calculate and report on one composite measure, the communication about medicine. So, you know, the results of using the item set in conjunction with Clinician & Group [Survey], you can use it to report at various levels.

Next slide please. So in the last few minutes before we jump into questions, I wanted to quickly review the work that we're doing in developing an item set to address health literacy for the CAHPS Hospital Survey. This is currently being field tested. Again, it's a supplemental item set for H-CAHPS. The domains that are included in this item set are patient-provider communication again, we have a series of items that are focused on discharge planning and coordination, so, you know, what a patient was told prior to being discharged from the hospital, communication about medications again, communication about test results, and communication about forms. And as I said, this is an item set that's currently being field tested and that will be released sometime in the future.

The other item set that's being developed currently as a supplemental item set for the CAHPS Health Plan Survey is currently in the process of being cognitively tested so, you know, we're just starting out with this project. And we hope that it will be available by late summer 2012. The domains for the CAHPS Health Plan, Health Literacy Item Set include health plan information that's available on a health plan website, communication with customer service, information about coverage and benefits, grievances and appeals, claims processing and interpreter services. So, you know, as you can see, the domains or the topics that are included in this item set are really focused on the health plan setting. As opposed to the version that is included for Clinician & Group [Survey] and the version that's being developed for the H-CAHPS survey.

And then as my last slide, I just want to take a moment to acknowledge AHRQ for its commitment to really improving how we measure, how health providers are doing in relation to health literacy, and just for their commitment to health literacy across the board, in particular, Cindy Brach. I would also like to take a moment to thank the stakeholders who have participated on all these projects and who have provided invaluable feedback and, of course, to our field test partners, the Affinity Health Plan and the University of Mississippi for their invaluable help in field testing the item set.

And with that I think I will turn it back over to you Carla and I see there is a lot of questions so I guess we should move right into that.

Carla Zema

We do Beverly. What I did was I put up your slide about the short version of the health literacy item set because you have four bullet points -- you have four items in the bullet points, but it says five items so lots of questions about are there four? Are there five? So everyone should be looking at the short version of the health literacy item set. We will get clarification from Beverly on that one.

Beverly Weidmer

Let me move back to that.

Carla Zema

That's okay. I want to thank all of our speakers. Again, we have a lot of questions so I just want to remind you if you want to ask a question, you just click on the "ask a question" button at the bottom of your screen and while Beverly is checking her notes for that one, I'm going to just kind of remind everyone that if you want to continue to receive or if you would like to receive information about upcoming CAHPS events or any updates about these two item sets, if you go to the CAHPS website which is www.cahps.ahrq.gov you will see a little button on the top that says e-mail updates. If you select that button, you will be able to sign up for the CAHPS listserv. These item sets again are part of the Clinician Group Survey so you can just select to receive just Clinician & Group Survey updates and you will be made aware of all our upcoming events and like I said, any updates to those item sets. After the webcast, if you have questions or comments we have -- the CAHPS User Network has a free technical assistance line; you can e-mail it at cahps1@ahrq.gov. You can also call 1-800-492-9261. Visit the CAHPS web site. After the [webcast], all the presenter slides are already out there, but we will also be posting a recording of the webcast as well as a written transcript.

Cindy Brach

Carla, if I could make an addendum on the e-mail updates which is we also have e-mail updates available on cultural competence and health literacy and those you can sign up for those from our AHRQ's homepage as opposed to the CAHPS page in a similar process of going to the email update button.

Carla Zema:

Absolutely.

Beverly Weidmer

Carla, this is Beverly. I found -- and I apologize -- for some reason, one of the items got dropped from my slide on the short version of the item set. The item that's missing is item 13, which is "In the last 12 months, how often did this doctor ask you to describe how you were going to follow these instructions?" But we will have that up on the website I believe soon and so, you know, attendees can always log in and obtain a copy of that or they can e-mail me and I can send that to them.

Carla Zema

Great. Well thank you so much for that clarification. And I'd like to ask both Rob and Beverly if you can kind of tell a little more information about your field test sites.

Robert Weech-Maldonado

Beverly, do you want to start?

Beverly Weidmer

Sure. So we -- our field test sites as I mentioned, Affinity Health Plan and the University of Mississippi, are two sites that volunteered to participate in the field test. They were familiar with the work that we were doing in the area of health literacy through various presentations and other information available through the AHRQ website. And we accepted their interest in participating in the field test in part because they had a strong interest and an institutional commitment to improving how they were communicating with patients and for enhancing the patient's health literacy skills. And also because each of these sites included a large proportion of minority and in the one case Spanish speaking patients and in the other that would allow us to adequately test the item set in both English and Spanish and then also look at subgroup differences in terms of how respondents responded to the questions in the survey.

Robert Weech-Maldonado

All right. Yes, and in terms of the cultural competence, we had also two Medicaid managed care plans. Affinity was also one of them and Care First was the other plan and basically they submitted a list of members. It was in essence a random sample stratified by race and ethnicity -- that way we would capture as much diversity in our response profile. And this would have been members of the plan and as you can see from the survey it was focused on the members patient experiences with

their doctor and so they would have had to have at least one patient -- one physician visit in the last year to be able to complete the survey or at least be eligible to complete the survey.

Carla Zema

Great. Thank you. And we have had several questions about benchmarking. I know our users really appreciate the fact that the User Network supports the national CAHPS Benchmarking Database. I just wanted to make a comment that currently at this time, we do not collect supplemental items into the CAHPS Benchmarking Database so from that perspective we do not have benchmarks available. I don't know if Rob or Beverly -- you want to comment on any data that you are aware of that might help people kind of benchmark where they are when they use these item sets.

Cindy Brach

Carla, if I can jump in there, it's Cindy. And these supplemental item sets were largely intended to be tools for quality improvement. So the best benchmark is yourself: where you administered these survey items at one period of time and then again perhaps after a year or some period after you have tried to improve and address these issues and then measure it again.

Carla Zema

Great, thank you.

Robert Weech-Maldonado

Yeah I agree with Cindy. Unfortunately at this point, yeah we would not have any benchmark data available. So that -- but it would be more from a quality improvement perspective in looking within in terms of what are your areas of strength and weaknesses and moving from there.

Carla Zema

Great. So Rob, I thought this was a great question. How do you ensure that these items themselves are actually -- that we're using to assess cultural competence, how do we ensure they are truly themselves culturally competent or linguistically appropriate? Can you talk about the development process and how you make sure that that is appropriate?

Robert Weech-Maldonado

Certainly, yes that's obviously an important question. And, you know, throughout the process we tried to ensure that we were getting the perspectives of the different, at least, representation from different racial ethnic as well as language subgroups. So starting, you know, with the translation, we ensure that it was a translation that followed the -- a process that has been already used and approved by the CAHPS to translate their instruments. And also in the cognitive testing, we tried to again have a representation across different groups. And then with the field tests, we have tried to use psychometric analysis to see that the measures are basically in terms of the construct validity of the measures across different groups. So we have had some analysis to date that shows that at least five of the measures are being consistently measured across three subgroups and specifically whites, African-Americans, and Hispanics. We still would need more data collected in the future to be able to

also assess for other groups like Asians, we just did not have enough samples to assess that. But that -- as far as using different tools and whether quantitative or qualitative to ensure the cultural and linguistic appropriateness of the instruments.

Carla Zema

Great, thank you. Similarly, Beverly, a question has been asked wondering how low literacy Spanish-speaking groups have done on CAHPS surveys. In their experience, the context and readability of the CAHPS surveys are too high for Hispanics with low levels of education.

Beverly Weidmer

Yeah, you know, Carla and we hear that over and over, but the fact is that we do routinely test all of our CAHPS core surveys as well as the supplemental measures in both English and Spanish, you know, through this fairly rigorous process of cognitive testing that typically includes at least two rounds and often three rounds of testing, with equal numbers of English speakers and Spanish speakers. And one of the primary objectives of these cognitive interviews is to really look at Spanish speaker's ability to understand the questions and understand the concepts that are trying to be measured. And we really make a very serious effort to simplify the questions as much as possible to use lay language that most Spanish speakers living in the continental United States can understand. So, you know, we try to use what's referred to as universal Spanish avoiding regionalisms that are only used by Spanish speakers from certain countries. And where we run into problems with the Spanish version of the question, we look to see whether we can modify the translation to make it easier to understand and if we find that we can't then we go back to the English version and see if there's any modifications that can be made to the English that would make it more translatable into Spanish. In general, we've had very good response from Spanish speakers. I think in the field tests that we did -- let me pull this up. We certainly had enough responses in Spanish to be able to adequately evaluate the Spanish version of the survey.

Carla Zema

I love it. You are so passionate about these you have all this information right at your fingertips. [laughing]

Beverly Weidmer

Yes, so we have comparable numbers in the Spanish in terms of Spanish completes for the survey. So, I mean I think two things that shouldn't be confused are, you know, the patient's understanding of the survey version in Spanish and then problems that are related to surveying low SES populations and there is clearly an overlap between respondents who prefer to complete the survey in Spanish and low SES. Now there's higher mobility rates and so often times if you get lower response rates for Spanish speakers, it's not necessarily because they didn't understand the Spanish version of the survey, it's that either they never received the survey in the first place or you know, they just have so much going on that they don't tend to complete surveys which is one of the reasons that we would recommend a mixed mode approach of data collection that involves both mail and telephone follow-up, so that you can improve and enhance your response rate with Spanish speakers in particular.

Carla Zema

That's a great point. I know, just generally for CAHPS, we often get that question about readability too that the readability or the reading level of the CAHPS surveys is a little bit higher than a lot of folks are aiming for as a low readability level but things that we do to make our items easier to understand like saying "in the last 12 months" as an introductory clause actually raises the readability. So some of that is counterintuitive but we do make sure through extensive testing that we are making sure that it is understandable for those with low literacy or low cognitive ability as well. So thank you. Rob, can you talk about whether the interpreter services that are included in your items that really do address American Sign Language?

Robert Weech-Maldonado

Unfortunately at this point, we focus on spoken language. But, you know, that would be an area that certainly is very important and this item set can be adapted for other populations as well so that would certainly be an area that we should work to adapt.

Carla Zema

Great. And I know we've had several questions about either American Sign Language or deaf/hard of hearing populations and I just wanted to make everyone aware that at our twelfth UGM and you can find us on our CAHPS website or call the CAHPS User Network; we can help you find it. Dr. Steve Barnett did a presentation. He is not with the CAHPS Consortium, but we have been coordinating with him through his project to adapt CAHPS for a deaf/hard of hearing population because as those of you that work with those individuals know there's also a high illiteracy rate so handing them a written questionnaire is often problematic because of the high illiteracy rates. And so that information about his project is available if you go under the event section and look for the twelfth UGM. Again, the speaker's name was Dr. Steve Barnett. You can find information about his project there.

So Rob, similarly staying on the language access item one of our listeners has made the comment that often times we equate cultural competence with interpreters and then it seems overly -- maybe overly done to have -- to devote 17 whole items to language access. Can you comment on that?

Robert Weech-Maldonado

Yes, it's certainly a good point, you know, when you look at the count or the number of items but actually when you look a little bit closer to the item set that in language access, a lot of the items are actually screeners because we want to make sure that the person answering a core item is basically the right person. So for example, we have three questions that actually assess whether English is or not their preferred language and then if it's another language, then they go on to respond to the item set. So when you look at actually in terms of core areas in the survey, there's probably about four or five where we ask about, you know, in terms of their -- whether they were informed about the right to interpreter services, whether they were treated with courtesy and respect, you know, and so forth; there's really a limited core number of items. The other items again are more screeners to make sure, you know, that for example, someone responding on interpreter services, someone that actually used an interpreter or that the office actually provided an interpreter and that it wasn't a family member providing the service so that's just an example of why there are so many items but when you

actually count the number of core items that are measuring actually assess, we're talking more about four or five items.

Carla Zema

Great, thank you.

Cindy Brach

Carla, could I jump in there for a second, please?

Carla Zema

Absolutely.

Cindy Brach

A couple of points. One is, I do often call linguistic competence the sort of no brainer of Cultural and Linguistically Appropriate Services. It's often the issue that organizations find the easiest to first address, not because it's easy to address, but because it's really obvious that if people don't speak the same language they're not going to be able to communicate effectively. But I also want to point out that these supplements are designed to be inserted into the Clinician & Group[s] CAHPS and you can choose which items are most relevant to your practice setting. So that if you serve a population that does not include any limited English proficiency patients, then you probably won't want to opt to include that whole interpreter services segment.

Carla Zema

Great, that's a good point. I know that many of you are not able to stay with us until the end, so what I've pushed up on your screen is a survey. We take these evaluations very seriously in terms of our planning for future sessions and so we will continue with Q&A. Don't leave yet, but I wanted to give those of you that aren't able to stay the opportunity to provide us some feedback on that.

I'm going to ask each of you to comment on this and Cindy I'd like you to weigh in as well. The question was, are these item sets intended for the entire year population or general population or are they really just supposed to be administered on limited English proficiency or minority patient populations?

Cindy Brach

Well, I would answer that very definitely, it is intended for all of your patients. First of all, you may not know exactly who might perceive that they are discriminated against or want to know their trust. It also provides you an opportunity to compare racial and ethnic groups so that, you know, to see if you have disparities within your organization so it really is very important to field it to the whole patient population.

Robert Weech-Maldonado

I would agree with Cindy and actually we found that, you know, when we look at different subgroups because when we did our field test we included across -- including whites and other minority groups -- that when you look at a specific domain, you find a positive relationship between that domain and the rating of care for all groups. So for example, trust was equally important for whites as it was for other diverse groups. So yes, definitely it should be fielded across all patients.

Carla Zema

Great. I agree. And the sampling for these is again is the general patient population. There is no specialized sampling for this because again it communicates the importance of using these items on your general population.

A comment came in and you can tell from the question and answer that the overlap of these areas because obviously while each speaker was talking about health literacy or cultural competence that there's a lot of overlap between these topics and one of our attendees even noticed a significant overlap in the item sets themselves. Can you guys talk about that overlap and why that is and that was very intentional.

Robert Weech-Maldonado

Beverly do you want to address that?

Beverly Weidmer

Yes, I mean health literacy and cultural competence are you know -- as I think as Cindy mentioned at the beginning of her presentation, are very much interrelated. You know, different camps will say that, you know, health literacy is part of cultural competence while others will say cultural competence is actually part of health literacy. I don't argue for one verses the other but they do overlap a lot of the same terrain and both topics are related to patient-centered care. And I think developing measures for each of these topics is a tool that can help disclose disparities in the health care that is provided to racial and ethnic minorities. We included health literacy items as part of the Cultural Competence Item Set because it gave us yet another opportunity to test those items. So yeah, that was deliberate.

Robert Weech-Maldonado

And I guess in the -- we do note where there is overlap and reference the other item set as you will notice in the documents for each of the item set that you would be able to know if there was an overlap with another survey.

Cindy Brach

And just to sort of point out another nexus, we are finishing up field testing of a Hospital CAHPS version of the Health Literacy Item Set and we actually have a set of interpreter questions included in that because we don't have a hospital level cultural competence instrument. We didn't include it in the Clinician & Group Health Literacy supplement because it was in the cultural competence so we really tried to be coordinating across them.

Carla Zema

And that's another good point, given the importance and the difficulties with coming up with really valid and reliable items that get at language access yet, those items were not just tested in this one but they're again being tested in the hospital version of them. We are in the process of updating all of our items because really this represents kind of the best survey science that we have in terms of the best way to ask items on language access and so what you'll see is that all of these items will replace some of our older items on interpreter's because again this is -- this is state-of-the-art research.

Someone also noted in terms of the importance of these items, certainly when we move to the version of the version of the Medical -- Patient-Centered Medical Home, Clinician & Group Survey, we also pulled some of the items from these item sets back into that survey as well because again, these transcend just looking at disparity. This is an issue that is first and foremost for the entire population and so because a lot of these items are so important they did get pulled over into that version as well and are being tested in terms of measuring medical home domains as well.

Just a couple -- and we've had several questions on translation of these items into languages other than Spanish. I will say the AHRQ and the CAHPS User Network have made a conscious decision that we will support all of our products in Spanish; however, due to limited resources we aren't able to support anything other than official translations in Spanish. We are looking into how the User Network can possibly support other users that have translated. We do know there are certain regions in the country that have pockets of different ethnic groups that require for example, Hmong's or different language transitions that we know are out there so we're looking at a mechanism for how we can maybe connect users to share those translations on them as well.

Another question that came in and this is obviously to both Rob and Beverly, in terms of that focus on the doctor, all of the questions ask about doctor because that is the CAHPS standard right now in terms of CAHPS Clinician & Group Surveys focus on doctor. Did any of the testing involve providers other than doctors?

Robert Weech-Maldonado

Not at this point. And again like you said, Carla, the original intent was this is going to be a supplemental item set to the Clinician & Group [Survey] and that of course, focuses on the doctor so obviously, you know, other providers are very important parts of the health care encounter and so I could only say that we should be at adopting these to other types of providers.

Beverly Weidmer

And this is Beverly, Carla. And as Rob said because this was developed, these items were developed specifically for the Clinician & Group Survey, they focus on the doctor and even in the cognitive testing that we did, the focus of the questions was specifically on the doctor. I did want to mention though that for the H-CAHPS Health Literacy Item Set, we do have a series of questions that focus on communication with nurses. So there are differences even though they all focus on health literacy, there are differences in both the items and what the focus is depending on the setting. And I also wanted to mention that there is a Patient-Centered Medical Home version of CAHPS that will be available in the future that did include items that focus on other providers in addition to the doctor.

Carla Zema

Absolutely. Thank you for mentioning that. I did want to say from a larger CAHPS perspective, we actually did do a significant cognitive testing on what we're calling the provider version of the survey again, recognizing that certainly care is not just focused on doctors and there are many cases in which nurse practitioners and physician assistants and others like those types of providers certainly serve in the role that we are kind of asking about the doctor. And so, the good news is that term tested very well and so as Beverly mentioned in the Patient-Centered Medical Home version, we did use the language about the provider and so we are currently in the process of evaluating all of the various Clinician & Group Survey versions and we'll be kind of -- there are so many moving parts of the Clinician & Group Survey now because so much of the new research, we're learning so much with the development work that's going on is -- you may see some changes to the Clinician & Group Survey very soon.

One last question is Beverly, do you see any evidence that suggests that writers actually change their behaviors to the information that's provided to them? I know you kind of went through the AMA tool kit and things but do providers really change?

Beverly Weidmer

I think it's too early to tell. I think this is a useful tool and people are just starting to use it and so I haven't really had an opportunity to evaluate the results, but I'm looking forward to more people adopting it and to be willing to share the results to see, you know, whether there really is any movement on the part of the providers.

Cindy Brach

And I'd like to add that since the health literacy supplement was first started, we at AHRQ have published something called the Health Literacy Universal Precautions Toolkit which is a set of 20 very short tools for providers to try and implement some of the health literacy preferred practices. So that we actually have something for providers who get feedback and understand that they're not as effective in their communication as perhaps they thought they were. Some strategies for them to be able to address that and do better next time.

Carla Zema

That's great. And from a Quality Improvement perspective, certainly communication is one of the core CAHPS composites to the core Clinician & Group Survey and so we do have a lot of evidence that when given feedback from these surveys, providers do look at the feedback, they take it seriously and they can improve. So we look for users to tell us and keep us up to date on how you're using these item sets and we would love to hear your stories and perhaps even integrate them into our Improvement Guide and other resources that we have as we go along.

So I want to thank everyone for attending. I know we weren't able to get to everyone's questions. Certainly this is a really important topic. If you have a question that was not asked and you would still like an answer to it, please feel free to e-mail the CAHPS User Network at cahps1@ahrq.gov and we will get you an answer to your question.

Thank you everyone again and we look forward to some of our upcoming webcasts later this spring. Thanks so much.

(END OF TRANSCRIPTION)